

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295078</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/03/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>HIGHLAND MANOR OF ELKO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2850 RUBY VISTA DRIVE ELKO, NV 89801</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility from 9/29/08 through 10/3/08. One complaint was investigated.</p> <p>The sample size was 19. Five random residents were added.</p> <p>Complaint #NV00019402. The complaint was substantiated with federal deficiencies cited. See Tags F 250 and F 411.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p>	F 000	<p>Please accept this plan of correction as this facility's credible allegation of compliance. The submission of the plan does not constitute an admission that the alleged deficiencies did in fact exist. This document is provided as evidence of this facility's desire to comply with regulations.</p>		12-08-08 11/17/08 pc
F 157 SS=D	<p><b>483.10(b)(11) NOTIFICATION OF CHANGES</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p>	F 157	<p><b>RECEIVED</b></p> <p>NOV 03 2008</p> <p>BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Aurice Hassen*

TITLE

*Administrator*

(X6) DATE

*10/29/08*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that the physician or mid-level practitioner was notified of abnormal laboratory values for 3 of 19 residents. (#9, #1, #2)</p> <p>Findings include:</p> <p>Resident #9: The resident was admitted to the facility on 6/16/08 with diagnoses including urosepsis, depression, pressure ulcers, renal failure, esophageal reflux, fracture of neck of femur, Alzheimer's dementia, congestive heart failure, and prostate cancer with urinary obstruction.</p> <p>Record review revealed that a urinalysis with culture and sensitivity studies was done on 8/12/08. The results were reported to the facility on 8/14/08, indicating that Resident #9 had a urinary tract infection.</p>	F 157	<p>Resident #9: Resident finished antibiotic and had no negative outcome</p> <p>Resident #1 Resident was receiving IV antibiotics at dialysis at the time for another infection. No negative outcome</p> <p>Resident #2 Resident was started on an antibiotic and had no negative outcome.</p> <p>All Residents have the potential to be affected.</p> <p>All nursing staff was re-educated on notifying the Physician or mid level practioner of lab results without delay 10-15-08</p> <p>All lab values will be called to Physician in a timely manner. If no answer, document and pass on to the next nurse, next shift. In the event there is no answer within 6 hours, Medical Director will be called.</p>	<p><del>12-08-08</del> 11/17/08 BC</p>

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F 157	<p>Continued From page 2</p> <p>Record review revealed an order for Ampicillin, an antibiotic, was written on 8/19/08. No evidence was found that Resident #9 had received any treatment for his urinary tract infection prior to 8/19/08.</p> <p>On 10/1/08 the Director of Nurses (DON) was interviewed and reported that she could not explain why there was a delay in the treatment of Resident #9's urinary tract infection.</p> <p>On 10/1/08 the laboratory nurse reported that laboratory results were faxed to the medical practitioner and then the practitioner would fax back orders to treat any abnormal lab results. She reported that she was not responsible for checking the disposition of the lab reports. She reported that the nurses randomly take faxes from the fax machine and address them. She further reported that there was no system in place to ensure that all labs were faxed to the practitioner or faxed back to the facility.</p> <p>Resident #1: The resident was admitted to the facility on 1/6/07 with diagnoses that included pain, anemia, failure to thrive, recurrent urinary tract infections, depression with behaviors renal disease and post cerebral vascular accident. He had an above the knee amputation and was receiving dialysis three times a week.</p> <p>Review of the record indicated that Resident #1 had a urinalysis with a culture and sensitivity (C&amp;S) due to the presence of bacteria. The results of the C&amp;S indicated the presence of E. faecalis, a bacteria, requiring the intervention of an antibiotic. There was no evidence that the results of the C&amp;S were conveyed to the attending medical practitioner. The resident was</p>	F 157	<p>D.O.N. or Designee will audit 10 labs weekly for 3 months to assure notification of Physician and appropriate treatment if necessary. If lab value found to have not been called to Physician, the nurse responsible will be disciplined as per protocol.</p> <p>D.O.N. and Administrator to monitor and report at QA meeting.</p>	12-8-08	

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F 157	Continued From page 3 not provided with treatment for the urinary tract infection.  Resident #2: The resident was admitted to the facility on 8/15/07 with diagnoses that included dementia with depression, urinary tract infections, chronic pain and convulsions.  On 8/16/08, the results of a urine culture and sensitivity indicated that Resident #2 had a urinary tract infection requiring antibiotic therapy. On 8/17/08, Resident #2 was taken the emergency department (ED) of the acute care hospital for evaluation of a seizure. Records from the ED indicated that she was given a prescription for the urinary tract infection by the ED physician. There was no evidence that Resident #2's physician was notified of the results of the urine culture and sensitivity and need for an antibiotic prior to the resident going to the ED.  In an interview with the DON on 9/29/08, she was not able to provide any evidence that the laboratory results had been provided to the medical practitioner.	F 157			
F 176 SS=D	Cross reference Tag F 505. Laboratory Services 483.10(n) SELF ADMINISTRATION OF DRUGS  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was	F 176			

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F 176	<p>Continued From page 4</p> <p>determined that the facility failed to conduct an interdisciplinary assessment for 1 of 5 random residents to self-administer medications. (Random Resident #5)</p> <p>Findings include:</p> <p>Random Resident #5: An observation and interview of the random resident was made on 10/1/08. The resident was at the nurses' station and stated that he was waiting for the nurse to replace his Nitroglycerin tablets. He stated that he carried three tablets at all times in a small envelope so that if he had chest pain, he could immediately take a Nitroglycerin tablet. He stated that he was to take one tablet every five minutes, times three, for chest pain. If the chest pain was unrelieved after the third pill, he or the nursing staff were to call 911. The resident stated that he informs the nursing staff whenever he has needed to take the Nitroglycerin. The resident stated he took two pills several days ago and had asked the nursing staff for the replacements.</p> <p>The licensed practical nurse (LPN) confirmed she was replacing two Nitroglycerin tablets that the resident reported he took on 9/30/08. He had informed the LPN he had taken them yesterday, but they were not replaced at that time.</p> <p>Review of the record failed to reveal evidence of an assessment by the interdisciplinary team that it was determined safe for Random Resident #5 to self-administer his Nitroglycerine.</p> <p>Cross reference F 281 Professional Standards of Practice</p>	F 176	<p>Resident #5</p> <p>No negative outcome from self administration of medication.</p> <p>All Residents capable of taking own medication have the potential of being affected.</p> <p>All nursing and I.D.T. team will be re-educated on the need for assessment to determine if resident is safe to take own medications.</p> <p>D.O.N. or Designee will audit every Resident who administers their own medication to assure they have been assessed and determined safe to do so.</p> <p>D.O.N. to present audit at monthly QA meeting for 3 continuous months.</p> <p>D.O.N. and Administrator to monitor.</p>	<p>12-08-08 11/17/08 bc</p>	
F 246	483.15(e)(1) ACCOMMODATION OF NEEDS	F 246			

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F 246 SS=D	<p>Continued From page 5</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review it was determined that the facility failed to allow residents to have their own belongings at the facility to create a more homelike environment for 2 of 19 residents (#19 and #2) and failed to provide eggs in a form preferred by residents for 1 of 19 residents (#12).</p> <p>Findings include:</p> <p>Resident #19: The resident was admitted to the facility on 11/10/05 with diagnoses including Alzheimer's dementia, hypercholesterolemia, conjunctivitis, disease of the oral soft tissues, pain, and lower extremity edema. The review of the resident's minimum data set (MDS) revealed that the resident is moderately impaired in his cognitive skills for daily decision making.</p> <p>On 10/2/08 the resident's daughter was interviewed and reported that the facility administrator had sent her a letter asking her to remove the resident's recliner chair. She also reported that resident sleeps in the recliner chair on a nightly basis. She further reported that the resident had slept in the chair at home for three years prior to his admission to the facility.</p>	F 246	<p>Resident #19 Recliner is still in room. Still has all clothes in closet. Resident no longer sleeps in Recliner at night. There have been no items taken off of his wall.</p> <p>Resident #2: Resident has all pictures hanging in her room. Explanation to Resident that she cannot hang items that are a fire safety hazard as per code.</p> <p>Resident #12: Resident has dx of Alzheimer's. A dietary interview had been done at admission with no mention of egg preference. He currently receives hard boiled eggs 2 x per week.</p> <p>All Resident's have the potential of being affected.</p>		<p>12-08-08 11/17/08 bc</p>

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F 246	<p>Continued From page 6</p> <p>The Administrator was interviewed on 10/2/08 and reported that the corporate office had informed her that many of the resident's belongings are creating an environment that was not aesthetically appropriate in light of the changes that the corporation is trying impose. She reported that she had informed the family that the recliner should be removed and replaced with a chair purchased by the facility to match with the new decor. She then reported that the chair was in poor repair, old and malodorous. She reported that she felt that the chair was unsafe for the resident.</p> <p>On 10/2/08, at 10:00 PM, the resident's recliner chair was observed and found to be functional and in good repair. No odors were noted from the chair. The resident was observed being assisted into the chair to sleep, and no safety issues were identified.</p> <p>Review of a letter the Administrator sent to the family of Resident #19 revealed that the facility was trying to replace some of the furniture in the residents' rooms. It further stated that "the facility will provide a chair for each resident, this will not be the recliner type." The letter from the Administrator to the family members of residents also contained a request for families to "provide no more than 5-7 outfits" at a time as there is not adequate closet space for more. Resident #19's daughter reported that the resident often goes through 5-7 outfits in one day. The letter also contained a directive that "items placed on the resident's wall should be framed or on the bulletin board that is provided by the facility."</p> <p>Resident #2: The resident was admitted to the</p>	F 246			

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F 246	<p>Continued From page 7</p> <p>facility on 8/15/07 with diagnoses that included dementia with depression, urinary tract infections, chronic pain and convulsions.</p> <p>During the group interview Resident #2 reported that she wished to place items on the wall without a bulletin board. She reported that the staff removed a lot of the items that she had on the wall to paint, but refused to put many items back on the wall. She reported that the facility had purchased a bulletin board for her, but that she does not like it and does not want it.</p> <p>The bulletin board that had been purchased for the resident was found in the conference room leaning against the wall.</p> <p>The Administrator was interviewed regarding the bulletin board, and reported that the resident refused to have it in her room.</p> <p>In the group interview it was revealed that many of the items that the residents wanted placed on the walls did not have frames. The residents in the group interview reported that "that is the way they would hang things on their walls at home" (without a bulletin board or a frame).</p> <p>Resident #12: The resident was admitted to the facility on 8/16/08 with diagnoses including diabetes, hypertension, anxiety, agitation, and congestive heart failure.</p> <p>An interview was conducted with Resident #12 on 10/1/08 at 10:40 AM. The resident was alert and oriented. When questioned about the facility food, the resident indicated the food was good, but he did not like scrambled eggs. The resident indicated he has always disliked scrambled eggs, but would eat hard boiled eggs. The resident</p>	F 246	<p>Suggestions by Resident Council will be requested by Administrator. Family will be educated at Family Council on what is safety hazard items- Copy of Resident Right's reviewed in Resident Council to assure they feel comfortable with requests that are made.</p> <p>D.O.N. Administrator or Designee will assure Resident has adequate and reasonable space for personal items.</p> <p>Administrator to report at monthly QA meetings.</p>	<del>12/08/08</del>

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F 246	Continued From page 8 indicated he had asked, but had not been served hard boiled eggs. The resident indicated no one from dietary had asked him about his food preferences since his admission.  A review of the medical record did not show evidence of a dietary food preference questionnaire.	F 246			
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that social services pursued making arrangements and exploring resources for dental treatment for 1 of 19 residents. (#19)  Findings include:  Resident #19: The resident was admitted to the facility on 11/10/05 with diagnoses including Alzheimer's dementia, hypercholesterolemia, conjunctivitis, disease of the oral soft tissues, pain, and lower extremity edema. Review of the resident's minimum data set (MDS) revealed that the resident is moderately impaired in his cognitive skills for daily decision making. The resident's daughter is his power of attorney for decision making.  A "Progress Note" dated 9/15/07 read: "spoke	F 250			

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F 250	<p>Continued From page 9</p> <p>with daughter who said that the resident has an appointment with the dentist on Monday." Record review revealed that Resident #19 was treated by the dentist on 9/17/08 after the resident's daughter made an appointment for him to be evaluated. Review of a document faxed by the dentist to the facility on 9/17/08, reported that at that time Resident #19 was diagnosed with a "mouth infection" and was treated with antibiotics.</p> <p>Review of a fax revealed that on 9/17/08 the dentist had seen Resident #19 and ordered antibiotic for "red and swollen gums".</p> <p>The DON was interviewed on 10/1/08, at 2:00 PM, and reported that Resident #19 had an infection but the infected tooth had fallen out on 9/15/07, and that the infection resolved after that.</p> <p>The resident's daughter was interviewed and reported that her father has had very poor dentition "for some time." She reported that she had discussed her father's need for dental care with the facility in January of 2008. She reported that Resident #19 has had no treatment to his teeth. She further reported that the resident and his wife were unable to pay for the needed dental treatment and that she had made the facility aware of this.</p> <p>Review the "Care Conference History" data revealed that a care conference was conducted on 3/13/08 with the resident's daughter. The notes read: "Dental care needed, extraction. Medicaid is an issue on Dental Surgeon. Jagged teeth must be removed. Has had pain." The next care conference notes on 6/12/08 read: "Social Worker will make a dentist appointment."</p>	F 250	<p>Resident #19</p> <p>Mouth infection healed in 9-07. Appointment has been made with local Dentist and he referred to Dentist in Reno for Oral Surgery. Appointment has been set for November 2008. Resident does not appear to have chewing or pain related to teeth- no weight loss.</p> <p>All Residents have the potential of being affected.</p> <p>Social Worker will be re-educated on the follow through with Dental appointments. Administrator currently trying to find Facility Dentist to provide monthly visits. Review of Medical history, Dental history at time of admission.</p> <p>D.O.N. or Administrator will audit 5 Residents a month x 3 to assure medically related services are being given. Results to be reported at monthly QA meeting</p> <p>Administrator to monitor.</p>	<p>12-10-08</p> <p>11/17/08</p> <p>BC</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295078</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/03/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>HIGHLAND MANOR OF ELKO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2850 RUBY VISTA DRIVE ELKO, NV 89801</b>		
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F 250	Continued From page 10  Review of a "Progress Note" written by the social worker on 6/13/08 read: "Called resident's daughter left message - informed her that it would cost \$375.00 to have the resident put under to have rotten teeth extracted and \$175.00 per tooth - asked if she would be willing to pay for it."  Review of the "Care Conference History" notes revealed an entry dated 8/28/08, that contained no reference to the resident's dental needs.  The facility Administrator was interviewed on 10/1/08 at 3:30 PM and reported that she was not aware that the facility was obligated to provide the resident's dental care.  On 10/1/08 at 3:45 PM the Social Worker was interviewed and reported that she did not know that the facility was responsible for providing dental care for this resident. She further reported that since the family was unable to pay for dental services that no action would be taken.	F 250			
F 274 SS=B	Cross reference Tag F 411 Dental Services 483.20(b)(2)(ii) RESIDENT ASSESSMENT- WHEN REQUIRED  A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 274			

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F 274	<p>Continued From page 11 requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined that the facility failed to conduct a significant change Minimum Data Set (MDS) for residents with a significant change in their physical or medical status for 3 of 19 residents. (#2, #13, and #5 )</p> <p>Findings include:</p> <p>A significant change MDS is indicated if there is decline or improvement of residents in two or more areas. The changes would not resolve without some type of intervention and the areas would require review by the various disciplines and/or revision of the care plan.</p> <p>Resident #2: The resident was admitted to the facility on 8/15/07 with diagnoses that included dementia with depression, urinary tract infections, chronic pain and convulsions.</p> <p>Quarterly MDS assessments were conducted on 5/16/08 and 8/16/08. In the mood/behavioral/psychosocial areas, Resident #2 changed from no indicators to a negative state with repetitive verbalizations, persistent anger and being verbal abusive. In the areas of Activities of Daily Living (ADLs), she declined from being independent in transferring to needing supervision, from being independent in dressing to needing limited assistance and in the area of eating from being independent to needing supervision. In the area of toileting, Resident #2</p>	F 274	<p>Resident #2 No negative outcome. Significant Change Assessment done in September 07. Has no change since.</p> <p>Resident #13 No negative outcome. Quarterly Assessment done. Has no change since.</p> <p>Resident #5: No negative outcome. Quarterly Assessment done. Has no change since.</p> <p>All Residents have the potential to be affected.</p> <p>MDS and IDT team will be re- educated on the requirement of significant change and when there has been a change on Resident's Physical or mental condition. This must be within 14 days of determination.</p>	<p>12-08-08 11/17/08 bc</p>	

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F 274	<p>Continued From page 12</p> <p>declined from being occasionally incontinent to being frequently incontinent. There was one area of improvement, in hygiene/bathing, where she went from being totally dependent to needing limited assist.</p> <p>In an interview with the MDS Coordinator on 9/30/08, she acknowledged that a significant change MDS was appropriate for Resident #2.</p> <p>Resident #13: The resident was admitted to the facility on 8/13/07. Diagnoses included debility, urinary tract infections, cataracts, esophageal reflux, arthritis, hypertension, depression, chronic pain and a history of cancer of the breast.</p> <p>A quarterly MDS was completed on 5/16/08 and an annual assessment completed on 8/13/08. The annual MDS indicated significant changes in the areas of mood/behaviors/psychosocial with no indicators present at the quarterly assessment with noted withdrawal in activities and social interactions at the time of the annual assessment. Changes were noted in the areas of ADL's with transferring abilities going from supervision to limited assist, dressing going from no indications to needing limited assist and bath and hygiene from no indicators to needing limited assistance.</p> <p>The MDS coordinator agreed that a significant change had occurred with Resident #13.</p> <p>Resident #5: This resident was 76 years old and admitted to the facility on 10/9/06. Her primary diagnoses included Parkinson's disease and dementia. Review of the record revealed the following MDS assessments:</p> <p>10/3/07, Annual MDS</p>	F 274	<p>D.O.N. and Administrator to audit 3 Residents weekly at Care plans to assure correct Assessments have been done and monitor for change.</p> <p>D.O.N. and Administrator will bring results of audit to monthly QA meeting for the next 3 months.</p> <p>Administrator to Monitor.</p>		12-08-08

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F 274	Continued From page 13 December 2007, Quarterly MDS 3/28/08, Quarterly MDS with changes in more that three areas: improvement in behaviors, but a decline in transfers, ambulation, dressing, eating, range of motion, bowel and bladder needs. 6/20/08, Quarterly MDS 9/23/08, Annual MDS with changes is more that three areas: further decline in transfers, dressing, eating, hygiene, range of motion and bladder needs.  No re-evaluation following either the 3/28/08 or the 9/23/08 assessments were done to determine whether there had been significant changes. The 3/28/08 assessments remained the same for the 6/20/08 assessment indicating these had been a permanent change.  An interview with the minimum data set (MDS) assessment coordinator on 9/30/08, revealed the MDS reviews were not being evaluated for indications of significant changes. She stated this was due to some staff that were not familiar with the MDS process completing sections of the MDS. As a result in residents with a significant change were not identified.	F 274			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview it was determined that the facility failed to ensure that the nursing staff clarified medication orders for 1 of 19 residents (#1), failed to ensure documentation of nursing activities and	F 281			

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F 281	<p>Continued From page 14</p> <p>resident conditions for 2 of 19 residents and 1 of 5 random residents (#2, #13, and Random Resident #1), and failed to ensure that the nursing staff followed the standards of practice for respiratory inhalants for 1 of 5 random residents (Random Resident #5)</p> <p>Findings include:</p> <p>Resident #1: The resident was admitted to the facility on 1/6/07 with diagnoses that included pain, anemia, failure to thrive, recurrent urinary tract infections, depression with behaviors renal dialysis and post cerebral vascular accident. He had an above the knee amputation and was receiving dialysis three times a week.</p> <p>Review of the record revealed a Psychotropic Drug Review dated 5/12/08 that noted that the resident was experiencing anger and was verbally abusive to the staff. The recommendation was to increase the dosage of his existing antidepressant. The physician indicated that he agreed with the recommendation, but failed to write an order to increase the medication. A notation on the form indicated that the form came back without an increase in dosage, but there was no evidence that the professional staff had attempted to obtain a new order for the needed medication.</p> <p>Resident #2: The resident was admitted to the facility on 8/15/07, with diagnoses that included dementia with depression, urinary tract infections, chronic pain and convulsions.</p> <p>Review of the record revealed documentation in the progress notes (by the nursing staff) that Resident #2 had experienced a seizure the</p>	F 281	<p>Resident #1: Has had no negative outcome. No behaviors shown. Documentation being done, med orders have now been clarified.</p> <p>Resident #2: Has had no other incidents of seizures and UTI. No negative outcome. Documentation is being done.</p> <p>Resident #5 Currently has order for self administration of Nitro. Nurse documentation on affects. No negative outcome.</p> <p>Resident #13: Documentation being done</p> <p>All Resident's have the potential to be affected.</p> <p>All nursing staff will be re-educated on the necessity of clarifying medication orders, the need to document nursing activities, resident conditions and to make sure that nursing staff follows the Standards of Practice for respiratory inhalants.</p>		<p>12-08-08 11/17/08 BC</p>

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F 281	<p>Continued From page 15</p> <p>evening of 8/17/08. A cell phone message was left with the physician's assistant and the resident's condition was monitored. Also found in the record was a discharge form from the acute care emergency department dated the same evening stating that the resident had been treated for post seizures and a urinary tract infection. The record contained no documentation regarding the the resident's transfer to the hospital, that the physician assistant had responded back to the message left on his cell phone or that an order had been obtained for the transfer. The record also did not contain any documentation of the resident's return to the facility.</p> <p>In an interview with the DON on 9/30/08, she concurred that there was no evidence of a physicians order for the transfer or any documentation by nursing staff regarding the transfer or the return of the resident to the facility. The interview revealed that she did not know why the resident was transferred, but that she thought the resident had respiratory problems following the seizure. She further stated that it was facility policy to obtain an order for transfer to the hospital.</p> <p>Resident #13: The resident was admitted to the facility on 8/13/07. Diagnoses included debility, urinary tract infections, cataracts, esophageal reflux, arthritis, hypertension, depression, chronic pain and a history of cancer of the breast.</p> <p>Review of the resident's record disclosed that, on 4/30/08, the facility was notified by the laboratory of a critical value of Methicillin Resistant Staphylococcus Aureus (MRSA) in her urine. The documentation indicated that Resident #13 was</p>	F 281	<p>D.O.N. or Designee will audit 5 orders weekly to assure medication orders clarified, documentation of nursing activities and Resident's conditions are done. Also that nursing staff follow the Standards of Practice for Respiratory inhalants. All nurses will monitored one time per week for three months giving respiratory inhalants.</p> <p>D.O.N. will present results of audit at monthly QA meeting for three months.</p> <p>Administrator to monitor.</p>	12-08-08	

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F 281	<p>Continued From page 16</p> <p>placed in contact isolation. After 5/4/08, there was no additional documentation to indicate the status of the contact isolation, when the contact isolation was discontinued, or of a negative urine culture.</p> <p>An interview with the DON failed to provide an explanation for the lack of documentation in Resident #13's record.</p> <p>Random Resident #1: On 10/1/08 during a morning medication pass on 400 Hall the resident was given an inhaler (Flovent) after which she was instructed to drink a cup of water. The packaging indicated that, after inhalation, the mouth was to be rinsed with water. The Drug Information Handbook for Nursing 2007 (Lexicomp) 8th Edition, indicated that rinsing after inhalation reduces the incidence of candidiasis (a thrush like condition).</p> <p>Random Resident #5: An observation and interview of the resident at the nurses' station was made on 10/1/08. The resident stated that he was waiting for the nurse to replace his nitroglycerin tablets. The resident stated that he informed the nursing staff whenever he has needed to take the Nitroglycerin. Random Resident #5 stated he had needed to take two pills several days ago and had asked the nursing staff for the replacements.</p> <p>The licensed practical nurse confirmed she was replacing two Nitroglycerin tablets that Random Resident #5 reported he had taken on Tuesday (9/30/08). He had informed the LPN he had taken them yesterday, but they were not replaced at that time. This LPN confirmed the resident tells the nursing staff when he takes them and the nursing staff were to document their use.</p>	F 281			

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F 281	Continued From page 17	F 281	Resident #3: New alarm attached. No negative outcome.	12-08-08 <i>11/17/08</i> <i>bc</i>
F 323 SS=D	<p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to ensure the bed alarm was functioning properly in order to prevent a fall resulting in injury for 1 of 19 residents. (#3)</p> <p>Findings include:</p> <p>Resident #3: The resident was admitted to the facility on 12/5/07 with diagnoses including hypertension, lumbar fracture, history of falls, and dementia. The resident was ambulatory on admission.</p> <p>Review of the medical record revealed that Resident #3 suffered a fall and femur fracture on 7/9/08. Review of the facility's investigation of the fall revealed that the bed alarm was on the bed, but not functioning properly. The volume of the alarm was turned down. A review of the care plan approach added after the fall indicated the bed alarm volume should be checked to ensure it</p>	F 323	<p>All Residents have the ability to be affected.</p> <p>All staff will be re-educated on making sure alarms are tested and working before attaching. Maintenance to do monthly check on all alarms in facility to assure in good working condition.</p> <p>D.O.N. or Designee will test 5 alarms per week to assure alarms have been checked and are working.</p> <p>D.O.N. will bring results of testing to monthly QA meeting for 3 months.</p> <p>D.O.N. to monitor.</p>	

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F 323	Continued From page 18 is "turned up."  Review of physician's orders revealed an order dated 1/24/08 to check the chair and bed alarms at the beginning of each shift to ensure that they were working properly. There was also an order dated 1/24/08 to check the bed alarm on rounds at night.  A review of the check sheet for the alarms revealed the sheet was initialed indicating that the bed alarm was in place and functioning on 7/9/08 prior to the fall.	F 323	Resident# 7: Resident is currently gaining weight. No negative outcome.  All Residents have the potential to be affected.	12-08-08 11/17/08
F 325 SS=D	<b>483.25(i) NUTRITION</b>  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to maintain acceptable parameters of body weight based on a comprehensive assessment for 1 of 19 residents. (#7)  Findings include:  Resident #7: The resident was admitted to the	F 325	Facility has obtained a new Dietician to monitor weekly weight loss and dietary assessments. All weight loss concerns will be discussed in weekly weight meeting with Dietician, along with dietary suggestion to Physician. New order to be placed on meal ticket if issued by Physician.  Dietary Supervisor will monitor all Residents with monthly weight loss to assure nutritional status is being assessed with a therapeutic diet as ordered.  Dietary Supervisor will bring results of audit to monthly QA meeting.  Administrator to monitor.	

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F 325	<p>Continued From page 19</p> <p>facility on 5/30/08, with diagnoses that included Type 2 diabetes, congestive heart failure, urinary tract infection, muscle weakness, history of transient ischemic attack, and hypertension. His minimum data set (MDS) dated 6/10/08 revealed the resident was eating with supervision and set-up help only. His MDS on 8/22/08 revealed a significant decline occurred with regard to eating, with the resident requiring extensive assistance.</p> <p>Record review revealed that Resident #7 experienced a 10.5% weight loss over a 2-month period. Her monthly weights were recorded as follows:</p> <p>6/10/08 - 152 7/29/08 - 156 8/22/08 - 136</p> <p>The record reflected that Resident #7 was assessed by the dietitian on 6/10/08. The dietitian wrote that the resident needed "a therapeutic diet R/T diagnosis of diabetes mellitus (DM), so dietary will provide no concentrated sweets (NCS) diet and we will monitor for signs/symptoms (S/S) of hypo/hyperglycemia." This was the only assessment made by a dietitian until 8/30/08, when the facility hired a new dietitian to assess residents once a month.</p> <p>At the facility's monthly weight meeting on 8/10/08, the Director of Nurses (DON) noted that Resident #7 had lost 16 pounds. On 8/17/08, Employee #2 wrote "Will continue to encourage fluids and PO intake. Will also see that he gets a supplement often."</p> <p>A record review did not provide evidence that this recommendation was followed or monitored.</p>	F 325			

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F 325	Continued From page 20 Meal intake records were not consistently documented by feeding assistants.  On 10/1/08, the DON stated that the facility's current procedure, as of 8/30/08, is to have the dietitian assess the nutritional status of the resident, call or fax the resident's physician for new dietary intake orders, and then notify the food service manager so that the order changes can be placed on the meal ticket. There was no written policy for this procedure, and there was no evidence the resident's physician had been contacted to review the dietary recommendation.	F 325	Resident #2 Orders corrected and physician's informed. No negative outcome.  Resident #3: Order received from Physician for clarification of 1 1/2 tablets. No negative outcome.  Resident #4: Order received from Physician to give oral or crushed. No negative outcome.	12-10-08 11/17/08 BC
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure the medication error rate was not five percent or greater.  Findings include:  Medication pass observations were conducted on 10/1/08 at 7:50 AM and 10/2/08 at 9:30 PM. The administration of 51 medications was observed. Four errors were noted for an error rate of 7.8 percent. The errors were as follows  Random Resident #2: The licensed practical nurse (LPN) was observed to administer enteric coated Aspirin 81 milligrams and Multivitamins with Minerals, one tablet to the resident. The	F 332	All Residents have the potential to be affected.  All nursing staff will be re-educated on medication administration and to follow a Physician order as written.  D.O.N. or Designee will audit nursing staff 2x month for 3 months to assure medication given as ordered.  D.O.N. will bring results of audit to monthly QA meeting for 3 months.  Administrator to monitor.	

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PRINTED: 10/17/2008  
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NAME OF PROVIDER OR SUPPLIER  <b>HIGHLAND MANOR OF ELKO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2850 RUBY VISTA DRIVE ELKO, NV 89801</b>		
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F 332	<p>Continued From page 21</p> <p>physician's orders read Aspirin 81 milligrams daily and Multivitamins, one tablet daily.</p> <p>An interview with the LPN revealed that the facility's pharmacy did not supply plain aspirin. She acknowledged there was no evidence the physician was informed that the resident was receiving enteric coated aspirin and a Multivitamin with Minerals. The LPN acknowledged that the facility had three types of Multivitamins available: Multivitamins, Multivitamins with Minerals and Multivitamins with Iron. (Two errors)</p> <p>Random Resident #3: The resident was administered Hydrocodone 10/325, one and 1/2 tablets. Review of the record revealed a physician's order written on 8/21/08, for Norco, (a brand name for Hydrocodone) 10/325, one tablet every four hours as needed. The Norco order was changed to four times a day on 8/29/08. The clinical record had no evidence that the dosage was increased to one and 1/2 tablets. The LPN confirmed there were no orders on the clinical record to reflect the increased dosage. The medical records staff could not provide any orders that were not filed to reflect the dosage change.</p> <p>Random Resident #4: At 9:30 PM on 10/2/08, an LPN administered 50 milligrams of crushed Benadryl. An interview revealed that the resident was to receive 50 milligrams of liquid Benadryl. The LPN stated the family had not brought the liquid medication to the facility. The staff administered a Benadryl tablet, crushing it with the other medications. The LPN confirmed there were no orders to change the medication from a liquid to a crushed pill. The LPN was not aware if the physician had been notified.</p>	F 332			

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F 361 SS=E	<p><b>483.35(a) DIETARY SERVICES - STAFFING</b></p> <p>The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.</p> <p>If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.</p> <p>A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the director of food service received frequently scheduled consultations from a qualified dietitian.</p> <p>Findings include:</p> <p>An interview with the food service manager on 9/29/08, revealed that the facility's contracted dietitian works at the facility once a month. The food service manager stated that he conducts all initial nutritional assessments for residents, and that he is not in frequent contact with the dietitian. According to food service manager, there is no policy in place regarding when to contact the dietitian, how to determine high-risk residents, or how soon nutritional assessments should be completed after admission and after a significant change determination.</p>	F 361	<p>New Dietician hired 10-1-08.</p> <p>Dietician will consult with Food Service Manager weekly for any nutritional issues. Dietician will review all assessments on new Residents and be available for consultation regarding any nutritional issues.</p> <p>All Residents have potential to be affected.</p> <p>D.O.N. or Designee will audit 5 nutrition Assessments monthly to assure Dietician consultation.</p> <p>D.O.N. will bring results of audit to monthly Q.A. for three months.</p> <p>Administrator to monitor.</p>		<p>12-8-08 11/17/08</p>

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F 371 SS=E	<p><b>483.35(i) SANITARY CONDITIONS</b></p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility did not ensure food was stored, prepared, distributed, and served under sanitary conditions.</p> <p>Findings include:</p> <p>During an inspection of the facility's kitchens on 9/29/08 and 9/30/08, the following observations were made:</p> <p>Food Storage: In the dry storage room, boxes of coffee and bags of paper products were stored directly on the floor. Items must be stored at least six inches above the floor in a manner that protects the food from contamination and permits easy cleaning of the storage area. A container of oatmeal was uncovered.</p> <p>Refrigerators: A container of cottage cheese had an expiration date of 9/18/08 was found. A container was labeled ambrosia, with a written date of 9/25/08 was found.</p> <p>Preparation of food: Food temperatures had not</p>	F 371	<p>Insect light now in place and functioning properly.</p> <p>Food storage: Items have been place at least 6" above floor and protected from contamination.</p> <p>Refrigerators: All containers are now dated and marked for expiration.</p> <p>Food Temperatures: Now being recorded by food service.</p> <p>All Residents have potential to be affected</p> <p>Kitchen staff will be educated on infection control with using thermometer and safe handling. The need for wearing gloves. Concentration of sanitizing solution for dishwasher also will be tested on a weekly. Staff will be educated on serving with proper temperatures as well as serving with proper condiments.</p>		<p>12-08-08 11/17/08 bc</p>

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F 371	Continued From page 24 been recorded since 9/26/08. It was observed that kitchen staff wiped their thermometers on their aprons while taking temperatures of meal items. A kitchen employee did not wear gloves during food preparation. There was no kit for testing the concentration of the sanitizing solution for the dishwashing machine.  Service of food: Bowls of oatmeal and fruit were observed being transported to the unit kitchens uncovered. There were no serving utensils used to serve turkey and beef at the 200 hall unit kitchen. Butter was in the unit kitchen refrigerator, but was not offered to residents to put on their plain bread during lunch. At the 400 hall unit kitchen, a bowl of oatmeal was observed untouched for 20 minutes on a dining room table until a resident came to have breakfast. Staff did not re-check the temperature of the oatmeal or offer to re-heat it. Five flies were observed in the 400 hall dining area.	F 371	Kitchen Supervisor will audit kitchen and pantry storage weekly for proper dates and storage.  Kitchen Supervisor will monitor kitchen staff daily to assure they are wearing gloves and following infection control procedures.  Kitchen Supervisor will bring results of audit to monthly QA meeting for 3 months.  Administrator to monitor.	<del>12-8-08</del>	
F 372 SS=B	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility failed to dispose of garbage properly.  Findings include:  A tour of the outside of the facility near the kitchen on 10/2/08, revealed two large dumpsters which were open and filled to the top with garbage. Dumpsters must have lids that fit tightly	F 372			

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F 372	Continued From page 25	F 372	Sanitation Company coming 6 days per week.	<div style="text-align: right;"> 12-8-08  11/17/08  <u>BC</u> </div>	
F 385 SS=E	<p>483.40(a) PHYSICIAN SERVICES</p> <p>A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that a physician provided oversight for physician assistant plans of care for 5 of 19 residents. (#10, #11, #2, #13, and #16)</p> <p>Findings include:</p> <p>Resident #10: The resident was readmitted to the facility on 5/16/08, with diagnoses including osteoporosis, fractures, deep vein thrombosis, congestive heart failure, anemia, depression, hypertension, atrial fibrillation, and chronic obstructive airway disease.</p> <p>Review of the medical record revealed that physician's assistant (PA) #9 was noted as the resident's primary physician. The record revealed that PA #9 saw Resident #10 three times between 5/16/08 and 10/1/08. The record failed to reveal evidence of physician visits from</p>	F 385	<p>Staff educated on the proper disposal of garbage and refuse.</p> <p>Kitchen Supervisor will audit garbage dumpster 3 x per week for 3 months.</p> <p>Kitchen Supervisor will bring results of audit to monthly QA meeting for 3 months.</p> <p>Administrator to monitor.</p>		

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F 385	<p>Continued From page 26</p> <p>5/16/08, when re-admitted to the facility, until 10/1/08.</p> <p>The review of the medical record revealed no documentation by the physician or any evidence of oversight by the physician of PA #9's care of Resident #10. No evidence was found that the physician had been made aware of any aspect of the resident's care.</p> <p>Resident # 11: The resident was admitted to the facility on 8/31/06 and readmitted on 8/21/07, with diagnoses that included acute cerebrovascular disease, urinary tract infection, cellulitis of the foot, restless leg syndrome, anemia, transient cerebral ischemia, chronic pain, Tietze's disease, hypertension, senile dementia, depression, asthma, and esophageal reflux.</p> <p>Review of the medical record revealed that physician's assistant (PA) #10 was noted as the resident's primary physician. Review of the record failed to reveal evidence of physician visits from 8/31/06, when re-admitted to the facility, until 8/21/07. Record review revealed that PA #10 saw Resident #11 thirty times between 10/20/07 and 9/13/08.</p> <p>Review of the medical record failed to reveal documentation by the physician or any evidence of oversight by the physician. No evidence was found that the physician had been made aware of any aspect of the resident's care.</p> <p>The Medical Director was interviewed on 10/2/08 at 12:30 PM, and reported that she was unaware of the requirement for the physician to take an active role in the resident's plan of care.</p> <p>Resident #2: The resident was admitted to the</p>	F 385	<p>Resident #10: Has been seen by Physician. No negative outcome.</p> <p>Resident #11: Resident will be seen by Physician within 60 days. No negative outcome.</p> <p>Resident #2: Residents care will be overseen by Physician and Physicians assist. No negative outcome.</p> <p>Resident #13: Residents care will be overseen by Physician. No negative outcome.</p> <p>Resident #16: Resident has expired.</p> <p>All Residents have the potential of being affected.</p> <p>Physicians will have active role in Resident's plan of care. Physician Assistants will report to Physician on Resident's plan of care. Resident's will not be assigned to Physician's Assistant as primary Physician.</p>		<p><del>12-08-08</del> 11/17/08 BC</p>

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F 385	<p>Continued From page 27</p> <p>facility on 8/15/07 with diagnoses that included dementia with depression, urinary tract infections, chronic pain and convulsions.</p> <p>Review of the record revealed that Resident #2 had a change in physicians on 3/3/08. She was seen by a physician's assistant on 3/12/08, 4/8/08, and 8/4/08. There was no evidence that the resident's care was being supervised by a physician until 8/6/08.</p> <p>Resident #13: The resident was admitted to the facility on 8/13/07. Diagnoses included debility, urinary tract infections, cataracts, esophageal reflux, arthritis, hypertension, depression, chronic pain and a history of cancer of the breast.</p> <p>Resident #13 had a change of attending physician on 3/3/08. Documentation showed that she was seen by a physician's assistant on 3/12/08, 4/14/08, and 7/12/08. There was no evidence of any visits by a physician in order to supervise and oversee her care.</p> <p>Resident 16: The resident was admitted to the facility 6/14/06 and readmitted to the facility 9/22/08, following an acute care hospitalization. His diagnoses included amputation of both of his legs, due to poor circulation and infection, and urosepsis. He was currently diagnosed with pneumonia.</p> <p>Review of his clinical record revealed that, since 1/1/08, Resident #16 had been seen by a physician's assistant for management of his medical care. There was no evidence in the clinical record to demonstrate the primary physician was aware of and agreed with the management prescribed by the physician's</p>	F 385	<p>D.O.N. or Designee will audit three monthly Physician visits to assure a Physician's Assistant is overseen by their covering Physician. Physician will review Physician Assistant's visits to assure proper treatment.</p> <p>Administrator will re-educate Physicians on regulation 483.40.</p> <p>D.O.N. will bring results of audit to monthly QA meeting for 3 months.</p> <p>Administrator to monitor.</p>		12-08-08

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F 385	Continued From page 28 assistant. Entries by the physician assistant on 9/9/08 and 9/10/08, indicated the physician's assistant was on vacation and that a physician would follow Resident #16's care needs during this time. There was no entry by a physician.	F 385	Resident #10:  Has since been seen by Physician .		
F 387 SS=E	Cross reference Tag F 387 Frequency of Physician Visits 483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS  The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.  A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.  This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that residents were seen and evaluated by a physician as required for 8 of 19 residents. (#10, #11, #4, #12, #15, #2, #13, and #16)  Findings include:  Resident #10: The resident was readmitted to the facility on 5/16/08, with diagnoses including osteoporosis, fractures, deep vein thrombosis, congestive heart failure, anemia, depression, hypertension, atrial fibrillation, and chronic obstructive airway disease.  Review of the medical record revealed that	F 387	Resident #11: Resident will be seen by a Physician in the next 60 days.  Resident #4: Resident will be seen by a Physician in the next 60 days.  Resident #12: Resident will be seen by Physician within 30 days.  Resident #15: Resident was discharged.  Resident #2: Resident will be seen by a Physician within the next 60 days.  Resident #13: Resident will be seen by a Physician in the next 60 days.  Resident #16: Resident expired  All Residents have the potential to be affected.		

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F 387	<p>Continued From page 29</p> <p>physician's assistant (PA) #9 was noted as the resident's primary physician. The record revealed that PA #9 saw Resident #10 three times between 5/16/08 and 10/1/08. The record failed to reveal evidence of physician visits from 5/16/08, when re-admitted to the facility, until 10/1/08.</p> <p>Resident # 11: The resident was admitted to the facility on 8/31/06 and readmitted on 8/21/07, with diagnoses that included acute cerebrovascular disease, urinary tract infection, cellulitis of the foot, restless leg syndrome, anemia, transient cerebral ischemia, chronic pain, Tietze's disease, hypertension, senile dementia, depression, asthma, and esophageal reflux.</p> <p>Review of the medical record revealed that physician's assistant (PA) #10 was noted as the resident's primary physician. Review of the record failed to reveal evidence of physician visits from 8/31/06, when re-admitted to the facility, until 8/21/07. Record review revealed that PA #10 saw Resident #11 thirty times between 10/20/07 and 9/13/08.</p> <p>The Medical Director was interviewed on 10/2/08 at 12:30 PM, and reported that she was unaware of the requirement for the physician to see the resident during the first 90 days of admission and then alternating visits with the physician's assistant thereafter.</p> <p>Resident #4: The resident was admitted to the facility on 6/26/08 with diagnoses including hip fracture, urinary tract infection, anxiety, osteoporosis, hypertension, diabetes, anemia, a cardiovascular disease.</p> <p>A review of the medical record revealed that the</p>	F 387	<p>Physicians and Physician Assistants will be re-educated on the necessity of the Residents care and needing to be overseen by Physician for first 90 days, no less than 1 time per month and one time every 60 days thereafter. All Physician Assistant visits will be reviewed and signed by Resident's Physician.</p> <p>Physician and/or Physician assistant will be given list of all Resident's requiring visit for each month. D.O.N. will audit to assure visits done monthly for three months and one time every 60 days thereafter.</p> <p>D.O.N. will bring results of audit to monthly QA meeting in three months.</p> <p>Administrator to monitor.</p>	<p>12-08-08 11/17/08 BC</p>	

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F 387	<p>Continued From page 30</p> <p>only progress note was by the physician's assistant on 8/16/08. There was no evidence of a physician's progress note or a visit by a physician since admission.</p> <p>An interview with the physician's assistant on 10/1/08 and the Medical Director on 10/2/08 revealed they were not aware of the requirements related to physician visits, frequency of visits, or the rules for alternating visits with the physician assistant.</p> <p>Resident #12: The resident was admitted to the facility on 8/16/08 with diagnoses including diabetes, hypertension, depression, anxiety, agitation, dementia, and congestive heart failure.</p> <p>A review of the medical record revealed no evidence of a physician visit or any progress notes from a physician or physician's assistant since admission.</p> <p>Resident #15: The resident was admitted to the facility on 6/2/08 and discharged on 7/11/08. The resident was readmitted on 7/17/08 and discharged on 7/28/08.</p> <p>A review of the medical record revealed no evidence of a physician or physician's assistant visit or any progress notes during either admission.</p> <p>Resident #2: The resident was admitted to the facility on 8/15/07 with diagnoses that included dementia with depression, urinary tract infections, chronic pain and convulsions.</p> <p>Review of the record revealed that Resident #2 had a change in physicians on 3/3/08. She was seen by a physician's assistant on 3/12/08,</p>	F 387			

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F 387	Continued From page 31 4/8/08, and 8/4/08. There was no evidence of a physician visit until 8/6/08.  Resident #13: The resident was admitted to the facility on 8/13/07. Diagnoses included debility, urinary tract infections, cataracts, esophageal reflux, arthritis, hypertension, depression, chronic pain and a history of cancer of the breast.  Resident #13 had a change of attending physician on 3/3/08. Documentation showed that she was seen by a physician's assistant on 3/12/08, 4/14/08, and 7/12/08. There was no evidence of any visits by a physician. in order to supervise and oversee her care. Resident 16: The resident was admitted to the facility 6/14/06 and readmitted to the facility 9/22/08, following an acute care hospitalization. His diagnoses included amputation of both of his legs, due to poor circulation and infection, and urosepsis. He was currently diagnosed with pneumonia.  Review of his clinical record revealed that since 1/1/08, Resident #16 had been seen by a physician's assistant for management of his medical care.	F 387			
F 411 SS=D	Cross Reference F 385 Physician Supervision 483.55(a) DENTAL SERVICES - SNF  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a	F 411			

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F 411	<p>Continued From page 32</p> <p>Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to assist residents to obtain and seek funding sources for dental care for 1 of 19 residents. (#19)</p> <p>Findings include:</p> <p>Resident #19: The resident was admitted to the facility on 11/10/05 with diagnoses including Alzheimer's dementia, hypercholesterolemia, conjunctivitis, disease of the oral soft tissues, pain, and lower extremity edema. Review of the resident's minimum data set (MDS) revealed that the resident is moderately impaired in his cognitive skills for daily decision making. The resident's daughter is his power of attorney for decision making.</p> <p>A "Progress Note" dated 9/15/07 read: "spoke with daughter who said that the resident has an appointment with the dentist on Monday." Record review revealed that Resident #19 was treated by the dentist on 9/17/08 after the resident's daughter made an appointment for him to be evaluated. Review of a document faxed by the dentist to the facility on 9/17/08, reported that at that time Resident #19 was diagnosed with a "mouth infection" and was treated with antibiotics.</p>	F 411	<p>Resident #19:</p> <p>Appointment being made with oral surgeon in Reno due to dentist in Elko will not work on Alzheimer's patients. Administrator working to obtain contract with Dentist to come into facility for annual check ups.</p> <p>All Residents with dental problems have the potential of being affected.</p> <p>Social Service will be re-educated on necessity of following through on the need for dental care and to seek funding.</p> <p>Administrator will audit 3 Residents monthly to assure follow thru on all appointments and if funding was obtained.</p> <p>Results of audit will be brought to QA meeting monthly for three months by Administrator.</p> <p>Administrator will monitor.</p>	<p>12-08-08</p> <p>11/17/08</p>

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F 411	<p>Continued From page 33</p> <p>Review of a fax revealed that on 9/17/08 the dentist had seen Resident #19 and ordered antibiotic for "red and swollen gums".</p> <p>The DON was interviewed on 10/1/08, at 2:00 PM, and reported that Resident #19 had an infection but the infected tooth had fallen out on 9/15/07, and that the infection resolved after that.</p> <p>The resident's daughter was interviewed and reported that her father has had very poor dentition "for some time." She reported that she had discussed her father's need for dental care with the facility in January of 2008. She reported that Resident #19 has had no treatment to his teeth. She further reported that the resident and his wife were unable to pay for the needed dental treatment and that she had made the facility aware of this.</p> <p>Review the "Care Conference History" data revealed that a care conference was conducted on 3/13/08 with the resident's daughter. The notes read: "Dental care needed, extraction. Medicaid is an issue on Dental Surgeon. Jagged teeth must be removed. Has had pain." The next care conference notes on 6/12/08 read: "Social Worker will make a dentist appointment."</p> <p>Review of a "Progress Note" written by the social worker on 6/13/08 read: "Called resident's daughter left message - informed her that it would cost \$375.00 to have the resident put under to have rotten teeth extracted and \$175.00 per tooth - asked if she would be willing to pay for it."</p> <p>The facility Administrator was interviewed on 10/1/08 at 3:30 PM and reported that she was not</p>	F 411			

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F 411	Continued From page 34 aware that the facility was obligated to provide the resident's dental care.  On 10/1/08 at 3:45 the Social Worker was interviewed and reported that she did not know that the facility was responsible for providing dental care for this resident. She further reported that since the family was unable to pay for dental services that no action would be taken.	F 411	All Residents on insulin have the potential of being affected.	<del>12-08-08</del> <b>11/17/08</b>	
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	D.O.N. will do monthly audit on Medication Carts to assure all medication is destroyed that has been outdated or expired.  D.O.N. to report results in monthly QA meeting for next 3 months.  D.O.N. to monitor.		

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F 431	<p>Continued From page 35</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy, it was determined the facility failed to ensure the proper labeling and storage of medication, and the proper discarding of expired drugs in three of four medication carts.</p> <p>Findings include:</p> <p>Observation of the 200 and 300 medication carts was conducted on 10/1/08.</p> <p>The medication cart for the 200 hall contained four opened multi-dose vials of insulin. Three vials stored in plastic containers were undated.</p> <p>An interview with the licensed practical nurse for the 200 hall stated that multi-dose vials would be dated when they were opened and discarded 30 days later. She stated that the plastic container was dated, not the vials themselves.</p> <p>The medication cart for the 300 hall contained seven open multi-dose vials of insulin in plastic containers with the individual resident's names. Five of these were dated with dates greater than 30 days old. These were: Novalog dated 7/2/08, Lantus 8/15/08, 8/13/08, and 8/22/08, and Novulin R dated 8/10/08.</p> <p>An interview with the LPN assigned to this hall stated she thought the multi-dose vials were to be</p>	F 431			

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F 431	Continued From page 36 discarded two months after opening.  Review of the facility policy identified as "Insulin Administration Procedures, revised 2/04", Page 2 described the vials of insulin were to be dated when opened. Loss of potency may occur when the bottle had been in use greater than 30 days. On 10/8/08, the medication cart for the 400 Hall was checked. Found in the cart was an open container of yogurt. While the yogurt container was dated as having been opened 10/8/08, it was not known how long it had been without refrigeration. The container was next to bottle of hand sanitizer.  Also in the cart was a vial of Novolin R Insulin which had not been dated when opened, another vial of Novolin Insulin which was dated as having been opened 11/27/07, a vial of Humalog Insulin without an open date and a vial Humalog Insulin dated 7/? (the year was unreadable).  The medication nurse asked this surveyor when an opened vial of medication should be discarded. The facility policy, written in 2/2004 stated to discard opened vials of medication after 30 days.	F 431			
F 441 SS=D	483.65(a) INFECTION CONTROL  The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and	F 441			

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F 441	<p>Continued From page 37 corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to maintain a complete, organized, and comprehensive infection control program. Based on observation it was determined that the facility failed to ensure staff followed infection control procedures during peri care and placement of urinary drainage bags to prevent the transmission of disease or infection for 1 of 19 residents. (#16)</p> <p>Findings include:</p> <p>Review of the Infection Control Log revealed that the data did not identify the causative agent for the individual infections or if the treatment modalities were effective. In an interview with the Infection Control Nurse, it was revealed that, while the infection control data did not include trending and patterning of the information, she did make note of specific problem areas and would post directives to the staff in the employee break room. Later the Administrator indicated that she maintained some facility trending and patterning of infections. The DON also indicated that that she used inservice sessions to address specific infection control concerns to the staff. However, no documentation of the inservices was included in the infection control data. Review of the log failed to reveal evidence that Resident #13 who was placed on contact isolation was entered into the Infection Control Log in the specific area to document residents placed in isolation. Refer to Tag F 281.</p>	F 441	<p>Resident #16: Resident has expired.</p> <p>Resident #13: UA resulted without MRSA.</p> <p>All Residents have potential to be affected. All nursing staff and C.N.A.s will be re-educated on correct procedure for infection control during peri care and placing all urinary drainage bags in a barrier bag.</p> <p>D.O.N. will document all infection control reports in log book. Trending and patterning of infection will be kept in same book.</p> <p>D.O.N. or Designee will audit 5 C.N.A.'s doing peri care weekly for 3 months.</p> <p>D.O.N. will bring results of audit to QA meeting monthly for three months.</p> <p>Administrator to monitor.</p>		<p><del>12-08-08</del> <b>11/17/08</b></p>

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F 441	<p>Continued From page 38</p> <p>The program lacked complete and comprehensive information that was localized in a specific area.</p> <p>Resident 16: The resident was admitted to the facility on 6/14/06. He was readmitted to the facility 9/22/08, following an acute care hospitalization. His diagnoses included amputation of both of his legs, due to poor circulation and infection, and urosepsis. He was currently diagnosed with pneumonia.</p> <p>Resident #16 was observed on 10/2/08, receiving peri-care by two certified nursing assistants (CNA). CNA#1 was performing peri care and CNA #2 was assisting. CNA #2 left the room and came back with a tube of barrier cream. She stated she found it on the linen cart. It was observed that CNA #1 was wearing gloves and applied the barrier cream to the resident's scrotum, rectum and perineal area with her right hand and supported Resident #16's buttocks with her left hand. She then picked up the tube of barrier cream with her right hand while still wearing the soiled gloves. She moved the tube to the foot of the bed. She removed the soiled gloves and discarded them, and then picked up the barrier cream tube with her ungloved hand. She stated she would take it back to the linen cart.</p> <p>Resident #16 had a suprapubic urinary catheter which drained into a drainage bag. Resident #16 was at risks for falls, so his bed was kept in a lowered position, close to the floor, when personal care was not being provided. After receiving the peri care, it was observed the CNA's placed the bed in a low position, which resulted in</p>	F 441			

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F 441	Continued From page 39 the urinary drainage bag coming in contact with the floor. The urinary drainage bag was not in any barrier bag. The CNA's acknowledged there was no barrier bag present in the room to place over the urinary drainage bag. It was also observed on 9/29/08 and 10/1/08, that the urinary drainage bag was not contained in a barrier bag.	F 441	Physicians and Physicians Assistance will be notified that all Resident care must be overseen by a physician. Residents will be seen or overseen every 60 days. D.O.N. or Designee will monitor to assure all Residents have a Physician overseeing their care and visits in an appropriate and timely sequence.		<del>12-08-08</del>  11/17/08 Be
F 501 SS=E	Interviews with a licensed practical nurse on 9/29/08, and the Director of Nursing on 10/2/08, both confirmed the urinary drainage bags were to be kept in barrier bags to minimize contamination. 483.75(i) MEDICAL DIRECTOR  The facility must designate a physician to serve as medical director.  The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide evidence the medical director was involved in ensuring physician services were available on a twenty-four hour basis, that physician visits were provided as required and that physician assistants were under the supervision of a physician for 7 of 19 residents. (#4, #12, #15, #10, #11, #2 and #13)  Findings include:  Review of the facility contract for the Medical Director revealed that under "responsibilities" item 3. "The Medical Director will inform physicians,	F 501	Administrator to monitor.		

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F 501	<p>Continued From page 40</p> <p>when requested, that they should follow clinical procedures and protocols that the facility, medical director, and/or medical staff agree are needed, or provide a valid medical rationale for deviating from them."</p> <p>Item 5. "The Medical Director may intervene directly in the care of other physicians' patients when the care of that patient is being compromised or direct harm or injury could occur."</p> <p>There was no evidence the Medical Director was involved in the care of those patients who had not been seen by their physician as required by regulation or that other physicians had been notified by the Medical Director about their delinquency in visiting patients. Examples are as follows:</p> <p>Resident #4: The resident was admitted to the facility on 6/26/08 with diagnoses including hip fracture, urinary tract infection, anxiety, osteoporosis, hypertension, diabetes, anemia, a cardiovascular disease.</p> <p>A review of the medical record revealed that the only progress note was by the physician's assistant on 8/16/08. There was no evidence of a physician's progress note or a visit by a physician since admission.</p> <p>An interview with the physician's assistant on 10/1/08 and the Medical Director on 10/2/08 revealed they were not aware of the requirements related to physician visits, frequency of visits, or the rules for alternating visits with the physician assistant.</p>	F 501	<p>Physicians and Physicians Assistance will be notified that all Resident care must be overseen by a physician. Residents will be seen or overseen every 60 days. D.O.N. or Designee will monitor to assure all Residents have a Physician overseeing their care and visits in an appropriate and timely sequence.</p> <p>Administrator to monitor.</p>	12-08-08	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>295078</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/03/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>HIGHLAND MANOR OF ELKO</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2850 RUBY VISTA DRIVE ELKO, NV 89801</b>		
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F 501	<p>Continued From page 41</p> <p>Resident #12: The resident was admitted to the facility on 8/16/08 with diagnoses including diabetes, hypertension, depression, anxiety, agitation, dementia, and congestive heart failure. A review of the medical record revealed no evidence of a physician visit or any progress notes from a physician or physician's assistant since admission.</p> <p>Resident #15: The resident was admitted to the facility on 6/2/08 and discharged on 7/11/08. The resident was readmitted on 7/17/08 and discharged on 7/28/08. A review of the medical record revealed no evidence of a physician or physician's assistant visit or any progress notes during either admission.</p> <p>Resident #10: The resident was readmitted to the facility on 5/16/08, with diagnoses including osteoporosis, fractures, deep vein thrombosis, congestive heart failure, anemia, depression, hypertension, atrial fibrillation, and chronic obstructive airway disease.</p> <p>Review of the medical record revealed that physician's assistant (PA) #9 was noted as the resident's primary physician. The record revealed that PA #9 saw Resident #10 three times between 5/16/08 and 10/1/08. The record failed to reveal evidence of physician visits from 5/16/08, when re-admitted to the facility, until 10/1/08.</p> <p>The review of the medical record revealed no documentation by the physician or any evidence of oversight by the physician of PA #9's care of Resident #10. No evidence was found that the physician had been made aware of any aspect of the resident's care.</p>	F 501			

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F 501	<p>Continued From page 42</p> <p>Resident # 11: The resident was admitted to the facility on 8/31/06 and readmitted on 8/21/07, with diagnoses that included acute cerebrovascular disease, urinary tract infection, cellulitis of the foot, restless leg syndrome, anemia, transient cerebral ischemia, chronic pain, Tietze's disease, hypertension, senile dementia, depression, asthma, and esophageal reflux.</p> <p>Review of the medical record revealed that physician's assistant (PA) #10 was noted as the resident's primary physician. Review of the record failed to reveal evidence of physician visits from 8/31/06, when re-admitted to the facility, until 8/21/07. Record review revealed that PA #10 saw Resident #11 30 times between 10/20/07 and 9/13/08.</p> <p>Review of the medical record failed to reveal documentation by the physician or any evidence of oversight by the physician. No evidence was found that the physician had been made aware of any aspect of the resident's care.</p> <p>Resident #2: The resident was admitted to the facility on 8/15/07 with diagnoses that included dementia with depression, urinary tract infections, chronic pain and convulsions.</p> <p>Review of the record revealed that Resident #2 had a change in physicians on 3/3/08. She was seen by a physician's assistant on 3/12/08, 4/8/08, and 8/4/08. There was no evidence that the resident's care was being supervised by a physician until 8/6/08.</p> <p>Resident #13: The resident was admitted to the facility on 8/13/07. Diagnoses included debility, urinary tract infections, cataracts, esophageal reflux, arthritis, hypertension, depression, chronic</p>	F 501					

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F 501	Continued From page 43 pain and a history of cancer of the breast.  Resident #13 had a change of attending physician on 3/3/08. Documentation showed that she was seen by a physician's assistant on 3/12/08, 4/14/08, and 7/12/08. There was no evidence of any visits by a physician in order to supervise and oversee her care.  In an interview with the medical director on 10/2/08, she indicated that she was not aware of the need for physician supervision or oversight of physician assistants.	F 501			
F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES  The facility must promptly notify the attending physician of the findings.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to notify the physician of laboratory findings for 2 of 19 residents. (Resident #1 and #9)  Findings include:  Resident #1: The resident was admitted to the facility on 1/6/07 with diagnoses that included pain, anemia, failure to thrive, recurrent urinary tract infections, depression with behaviors renal disease and post cerebral vascular accident. He had an above the knee amputation and was receiving dialysis three times a week.  Review of the record indicated that Resident #1 had a urinalysis with a culture and sensitivity (C&S) due to the presence of bacteria. The	F 505			

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F 505	<p>Continued From page 44</p> <p>results of the C&amp;S indicated the presence of E. faecalis, a bacteria, requiring the intervention of an antibiotic. There was no evidence that the results of the C&amp;S were conveyed to the attending medical practitioner. The resident was not provided with treatment for the urinary tract infection.</p> <p>In an interview with the DON on 9/29/08, she was not able to provide any evidence that the laboratory results had been provided to the medical practitioner.</p> <p>Resident #9: The resident was admitted to the facility on 6/16/08 with diagnoses including urosepsis, depression, pressure ulcers, renal failure, esophageal reflux, fracture of neck of femur, Alzheimer's dementia, congestive heart failure, and prostate cancer with urinary obstruction.</p> <p>Record review revealed that the resident had a urinalysis with culture and sensitivity studies done on 8/12/08. The results were reported to the facility on 8/14/08, indicating that the resident had a urinary tract infection.</p> <p>Record review revealed an order for Ampicillin, an antibiotic, was written on 8/19/08. No evidence was found that Resident #9 had received any treatment for his urinary tract infection prior to 8/19/08.</p> <p>On 10/1/08 the Director of Nurses (DON) was interviewed and reported that she could not explain why there was a delay in the treatment of Resident #9's urinary tract infection.</p> <p>On 10/1/08 the laboratory nurse reported that laboratory results were faxed to the medical</p>	F 505	<p>Resident #1 Has since had UA. No negative outcome.</p> <p>Resident #9: He is being treated for an infection. No negative outcome.</p> <p>All Residents have the potential to be affected.</p> <p>All nursing staff will be re-educated on the necessity of promptly notifying the Physician of lab results.</p> <p>D.O.N. or Designee will audit 5 labs weekly to assure Physicians are being notified of results.</p> <p>D.O.N. will bring results of audit to monthly QA meeting for 3 months.</p> <p>D.O.N. to monitor.</p>		12-08-08 <i>11/17/08 BC</i>

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F 505	<p>Continued From page 45</p> <p>practitioner and then the practitioner would fax back orders to treat any abnormal lab results. She reported that she was not responsible for checking the disposition of the lab reports. She reported that the nurses randomly take faxes from the fax machine and address them. She further reported that there was no system in place to ensure that all labs were faxed to the practitioner or faxed back to the facility.</p> <p>Resident #9: The resident was admitted to the facility on 6/16/08 with diagnoses including urosepsis, depression, pressure ulcers, renal failure, esophageal reflux, fracture of neck of femur, Alzheimer's dementia, congestive heart failure, and prostate cancer with urinary obstruction.</p> <p>Record review revealed that the resident had a urinalysis with culture and sensitivity studies done on 8/12/08 and the result was reported to the facility on 8/14/08, indicating that the resident had a urinary tract infection.</p> <p>Record review revealed an order for Ampicillin was written on 8/19/08. No evidence was found that resident #9 had received any treatment for his infection prior to 8/19/08.</p> <p>On 10/1/08 the DON was interviewed and reported that she could not explain why there was a delay in the treatment of the resident's urinary tract infection.</p> <p>On 10/1/08 the laboratory nurse reported that the result of the laboratory report is faxed to the provider and then the provider faxes back orders to treat any abnormal lab reports. She reported that she is not responsible for checking the</p>	F 505			

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F 505	Continued From page 46 disposition of the lab reports. She reported that the nurses randomly take faxes from the fax machine and address them. She further reported that there is no system in place to ensure that all labs are faxed to the physician or faxed back to the facility.	F 505			